DRVD INVESTIGATION REPORT

AN INVESTIGATION INTO THE SUICIDE OF THERESA WILKERSON

A 48 year-old female who committed suicide while participating in the Census Reduction Program of the Central Virginia Community Services Board.

DRVD CASE # 02-0182
Department for Rights of Virginians with Disabilities

TABLE OF CONTENTS

I. SUMMARY OF FACTS

On August 26, 2001, Theresa Wilkerson ("Ms. Wilkerson"), a resident in an apartment operated by the Central Virginia Community Services Board ("CVCSB") as a community placement, jumped to her death from the Rivermont Street Bridge in Lynchburg, Virginia. Ms. Wilkerson had lived in the apartment, as a participant in CVCSB's Census Reduction Program, since April of 2000. In her sixteen months as a program participant, Ms. Wilkerson expressed suicidal ideations on a number of occasions (including stating ideations involving jumping off of the Rivermont Street Bridge) and often displayed symptoms of her mental illness, Schizoaffective Disorder, all of which were either not recognized as symptoms of her mental illness or considered by CVCSB to be false and manipulative behaviors.

II. SUMMARY OF FINDINGS

Ms. Wilkerson died a preventable death. Her suicide at the age of 48 was the result of a failure, by her health care and community service providers, to recognize the symptomology and extent of her mental illness. The record of this case presents sad proof that Ms. Wilkerson's community placement, no matter how well-intentioned, was doomed to fail because the supports and services provided to her were inadequate and met the legal definition of neglect. In particular, the failure of Ms. Wilkerson's community service and health care workers to recognize and treat her Schizoaffective Disorder and CVCSB's determination that Ms. Wilkerson's behaviors were false and

[1] DRVD uses Ms. Wilkerson's name with the express permission of her parents.

manipulative, rather than symptoms of her Schizoaffective Disorder, resulted in a failure to create and/or implement an appropriate treatment plan.

III. METHODOLOGY OF INVESTIGATION

In the course of this investigation, DRVD reviewed Ms. Wilkerson's medical and community placement records including:

- Case notes, treatment plans, medical, and financial records maintained by CVCSB dating from April 2000 to August 2001;
- Medical and mental health records dating from 1987 until 2000 maintained by CVCSB; and
- Admission, medical, and discharge records from Lynchburg General Hospital, Catawba Hospital, and other facilities.

DRVD also conducted interviews with Ms. Wilkerson's family and the managerial and staff employees of CVCSB who provided community care and services to Ms. Wilkerson.

Finally, DRVD retained an expert, Dr. Ronald J. Koshes, to review the records, interview witnesses, and report his findings regarding the care and treatment received by Ms. Wilkerson. Dr. Koshes' findings are attached as Exhibit A to this Report.

On April 11, 2002, draft copies of this Report were sent to CVCSB and Ms. Wilkerson's parents. Each party was given the opportunity to submit a response and told that its response would be published with this Report if it was received by 1 May, 2002.

On April 24, 2002, DRVD received a response from Ms. Wilkerson's parents and their permission to publish same. Their response is attached as Exhibit B to this Report.

On April 30, 2002, DRVD received a response from CVCSB and its permission to publish same. CVCSB's response is attached as Exhibit C to this Report.

IV. FACTS

A. Prior to April, 2000

Ms. Wilkerson had a long history of psychiatric care and treatment. The records reviewed by DRVD indicate that, in the period from 1987-2000, she received several different, and sometimes inconsistent, diagnoses, including: Depression, Schizoaffective Disorder, Mixed Personality Disorder, Borderline Personality Disorder, Schizophrenia, Mild Mental Retardation, Mental Retardation, Major Depressive Episode, Psychosis Not Otherwise Specified, and Obsessive Compulsive Disorder. During these years, Ms. Wilkerson resided in several unsuccessful community placements. As a result, the majority of her time was either spent in mental health facilities (including Central State Hospital, Southern Virginia Mental Health Institute, Western State Hospital, and Catawba Hospital) or living with her parents. During this time, she was treated with medications including: Prozac, Clozaril, Paxil, Haldol, Clonazepam, Ativan, and Cogentin.

Also, during this period, Ms. Wilkerson received inconsistent diagnoses of a cognitive impairment. For example, in June of 1990, after a hospitalization, Ms. Wilkerson was identified as a person with Mental Retardation. However, in July of 1991, she was diagnosed with Schizophrenia and no Mental Retardation or other cognitive impairment was identified. However, in August of 1991, a social worker made note of Ms. Wilkerson having Mental Retardation. Diagnoses in the subsequent years varied,

describing her as a person with Mental Retardation, a person with "less than average intelligence," or "borderline intellectual functioning" and, in 1995, definitively stating that she did not have Mental Retardation, a finding contested by her parents.

B. April, 2000 – August, 2001

1. CVCSB's Census Reduction Program

In April 2000, Ms. Wilkerson was discharged from Southern Virginia Mental Health Institution and became a participant in CVCSB's Census Reduction Program ("CRP").

The CRP is a joint effort between CVCSB and the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services ("DMHMRSAS") designed to find and fund community-based residency, care, and treatment for long-term residents. CVCSB describes the services provided by the CRP as follows:

> Census Reduction Staff provides community-based services to individuals with a major mental illness whom [sic] have spent a significant number of days in an inpatient psychiatric facility. Program staff work to promote client independence by increasing community resources and supports for individuals. Services are individualized and designated to assist consumers in meeting their daily needs while living in the community.
> ***CVCSB Program Plan, Census Reduction Program, p. 1***

In an interview, a CVCSB managerial employee stated that potential CRP participants were referred to CVCSB by DMHMRSAS. DMHMRSAS would identify, to CVCSB, a person whom they believed could live and be treated in the community and asked CVCSB to develop a plan providing for a community placement. CVCSB was given an opportunity to study the person's case and decide whether or not it could

provide services to that person. If CVCSB felt it could provide services, it would develop a plan, setting forth broad-based goals and objectives and a budget covering everything from the cost of housing, treatment, and medication, to the cost of clothing and food. The plan was then forwarded to DMHMRSAS for approval. If DMHMRSAS approved the plan, it would provide funding.

All of the CVCSB personnel interviewed by DRVD indicated that the CRP has been very successful, resulting in approximately twenty successful community placements and only "one or two" instances where a CRP participant had been unable to continue to live and receive services in a community setting.

It should be noted, here, that all of the CVCSB personnel interviewed by DRVD showed an impressive dedication to the program. The CRP staffers who worked directly with Ms. Wilkerson obviously cared deeply about her, as a CRP participant and a friend. During interviews conducted almost three months after Ms. Wilkerson's death, her caseworkers and case manager were clearly in mourning for her. The contents and findings of this report should not be interpreted as attacks on CVCSB's dedication to Ms. Wilkerson.

2. Chronology of Events from April 2000 August 2001

Following is a chronology of significant events that occurred during Ms. Wilkerson's 16 months of participation in the CRP. The chronology is taken from records obtained from CVCSB, which included regular, and in most cases daily, case updates.

Date	Event
April 18, 2000	Ms. Wilkerson is discharged from Southern Virginia Mental Health Institution. She takes up residence at an apartment operated by CVCSB.
April 28, 2000	Ms. Wilkerson calls 911. She states that she is suicidal and specifically identifies an ideation of jumping off of the Rivermont Street Bridge. .
June 2, 2000	Ms. Wilkerson calls 911. She states that she wants to be returned to Southern Virginia Mental Health Institution or taken to Lynchburg General Hospital Emergency Room. Her caseworker, in her case note, states that she talked to Ms. Wilkerson and was "able to get her off ambulance."
June 26, 2000	Ms. Wilkerson grabs her roommate by the throat in retaliation for moving her toothbrush. Ms. Wilkerson then calls 911. Her caseworker, in her case note, indicates that she talked to Ms. Wilkerson about grabbing her roommate. She also indicates that she asked Ms. Wilkerson not to call 911 any more and unplugged the telephone.
June 29, 2000	Ms. Wilkerson calls 911. Her case worker states, in her case note, that she "told [Ms. Wilkerson] that if it [calling 911] continued, [Ms. Wilkerson], would have privileges taken away."
July 5, 2000	Ms. Wilkerson calls 911. Her caseworker states, in her case note, that she "explained that special outings/trips will be discontinued if this continues."
July 11, 2000	Ms. Wilkerson tells CRP staff that she is suicidal.
July 24, 2000	At her quarterly Mental Health Division Service Reauthorization, CRP staff indicates that Ms. Wilkerson's working diagnosis is 295.70 (Schizoaffective Disorder, Bipolar Type). CRP staff states that Ms. Wilkerson "has called 911 a few times." Under the section entitled "Current identified need for Services," CVCSB states that Ms. Wilkerson "conts to need an intensive level of services [and] support to promote medication and prevent rehospitalization."

August 7, 2000	At a Medicine Check/Psychiatric Examination, her doctor indicates that Ms. Wilkerson has experienced loss of appetite, drowsiness, agitation, fatigue, and "panic attacks." Her doctor also indicates that Ms. Wilkerson sometimes has auditory hallucinations and suicidal thoughts. The doctor did not order any changes in her medications.
September 4, 2000	Ms. Wilkerson tells CRP staff that she is suicidal.
September 17, 2000	Ms. Wilkerson tells CRP staff that she is suicidal.
September 29, 2000	Ms. Wilkerson calls 911, stating that she is suicidal. Her caseworker states, in her case note, that she "talked with Cl and redirected her. Cl calmed down, stated she felt better and agreed not to call 911."
October 2, 2000	Ms. Wilkerson tells CRP staff that she wants to visit other adult residences. Ms. Wilkerson's caseworker states, in her case note, that she "told Cl that if Cl did not call 911 and followed the rules through October, [case worker] would then call one adult home in the beginning of November."
October 13, 2000	Ms. Wilkerson tells CRP staff that she wants to visit other adult residences. Ms. Wilkerson's caseworker states, in her case note, that "Cl has looked at several ACR's and [case worker] has agreed to call another one in November if Cl does not call 911 or ER."
October 23, 2000	At her quarterly Mental Health Division Service Reauthorization, CRP staff indicates Ms. Wilkerson's working diagnosis is 295.70 (Schizoaffective Disorder, Bipolar Type). CRP staff states, incorrectly, that Ms. Wilkerson "has not called 911 this quarter." Under the section entitled "Current identified need for Services," CVCSB states that Ms. Wilkerson "conts to need an intensive level of services [and] support to promote medication and prevent rehospitalization."
November 6, 2000	At a Medicine Check/Psychiatric Examination, her doctor indicates that Ms. Wilkerson has experienced loss of appetite, drowsiness, weakness, memory loss, and fatigue. The doctor also indicates that Ms. Wilkerson sometimes has auditory hallucinations and suicidal thoughts. The doctor states Ms.

	Wilkerson "always has some complaint and continues to say she feels 'weak' (? sedated)." The doctor decreased her Klonopin dose, reasoning that Klonopin could act as a sedative, and added Paxil, to combat her panic attacks.
November 10, 2000	Ms. Wilkerson tells CRP staff that she is "hearing voices." CRP staff provided her with Haldol to combat the hallucinations.
December 20, 2000	Ms. Wilkerson calls 911, stating that people in her house were sticking her with pins. Her caseworker states, in her case notes, that she "explained the seriousness of making such accusations."
December 28, 2000	Ms. Wilkerson tells her caseworker that a CRP staff member had gotten a key to her bedroom, came in and stuck her with a pin. Her case worker states, in her case note, that she "Explained that no one had a key but her and that it is a serious issue when she accuses people of such things (as last week when the police and DSS were involved). [Ms. Wilkerson] is seeking attention and this is typical behavior when she does not get what she wants."
January 1, 2001	Ms. Wilkerson calls 911, stating that someone was sticking pins in her eyes and asks to be taken to the hospital. Ms. Wilkerson's case worker states, in her case note, that she spoke with a police officer and "Stated that Theresa did not need to be 'ECO'd' as she was requesting."
January 3, 2001	Ms. Wilkerson calls 911 and is taken to the Emergency Room, stating that she is hearing voices. Lynchburg General Hospital's Mental Health Consultation Report states "The patient while mentioning suicidality corrects herself and says that she is not now suicidal. She did this by making the statement and then looking down and then stating that she was not suicidal. Clearly, the patient is attempting to manipulate into securing hospitalization." The hospital diagnoses her as having "By history, schizoaffective disorder, rule out schizophrenia." Her case manager meets her at the hospital, arranges for her to receive Haldol and transports her home.

January 4, 2001	Ms. Wilkerson calls 911, reporting that she is suicidal. Her case manager states, in her case note, "Cl reported being suicidal and was reportedly very rude to EMT staff. When [case manager] arrived, Cl was laughing and appeared to be fine. Cl saw [case manager] and began reporting that someone had entered her room and scratched her. [Case manager] feels this is all for attention on client's part."
January 9, 2001	Ms. Wilkerson acts out aggressively toward CRP staff and her roommate. She leaves her residence carrying a clock and struck a car with the clock. She then assaults a neighbor. She was brought back into the residence, where she takes a "boom box" stereo and leaves the residence, breaking the stereo outside the residence. She then travels to a nearby restaurant and throws ketchup on a patron. Her caseworker then sought and received a temporary detention order, resulting in Ms. Wilkerson being taken to Lynchburg General Hospital emergency room. The Lynchburg General Hospital Mental Health Consultation report states that Ms. Wilkerson indicated that she had heard a voice (she stated it was Elvis Presley) telling her to "start a fight." Ms. Wilkerson was diagnosed as having Schizophrenia.
January 9-17, 2001	Ms. Wilkerson is admitted to and treated at Catawba Hospital pursuant to the temporary detention order. While at Catawba, she was diagnosed as having "Schizophrenia, Paranoid Type." Her Paxil and Klonopin prescriptions were discontinued. She was prescribed Cogentin.
January 7, 2001	Ms. Wilkerson is discharged from Catawba Hospital. Her case manager transports her home. Her case manager, in her case note, states "Cl voiced numerous somatic complaints on the ride home but this is typical."
January 8, 2001	At her quarterly Mental Health Division Service Reauthorization, CRP staff indicates Ms. Wilkerson's working diagnosis is 295.70 (Schizoaffective Disorder, Bipolar Type). CRP staff states "This quarter her calling 91 and the ER have increased." Under the section entitled "Current identified need for Services," CVCSB states that Ms. Wilkerson "conts to need an intensive level of services [and] support to promote medication and prevent rehospitalization."

January 29, 2001	Ms. Wilkerson physically assaults her roommate. Her roommate calls the police, resulting in Ms. Wilkerson being arrested and charged with assault and battery.
February 1, 2001	At 10:45 P.M., Ms. Wilkerson leaves her residence, walks to a local restaurant and calls 911, requesting to be taken to Southern Virginia Mental Health Institute or Western State Hospital.
February 3-4, 2001	Ms. Wilkerson acts in a verbally and physically aggressive manner toward CRP staff.
February 5, 2001	Ms. Wilkerson becomes angry at and aggressive toward her roommate. Her case worker states, in her case note, "[Ms. Wilkerson] stated she wanted to go to jail. Upon returning to the kitchen, Teresa [sic] threw her food at her roommate and threatened 'I'll kill you next time.'" The roommate called the police "who suggested roommate could pursue a warrant tonight or in the morning." The police officer spoke with Ms. Wilkerson and consulted with her caseworker to determine whether Ms. Wilkerson should be taken to the emergency room for a mental health consultation. The case worker stated "This writer advised [the police officer] that Teresa was not exhibiting any psychotic symptoms of her illness, that her behaviors were due to Teresa wanting to go to the jail or either the hospital."
February 6, 2001	Ms. Wilkerson threatens to physically harm her case manager. Later, Ms. Wilkerson calls 911 and is taken to the emergency room. While at the hospital, she is served with an arrest warrant and taken to jail.
February 6, 2001	Ms. Wilkerson is brought to the emergency room by police staff after she stated that she was suicidal and threatened to jump off of "the bridge." When CRP staff come to the hospital, Ms. Wilkerson refuses to return home with them, stating that she is suicidal. Ms. Wilkerson is subsequently taken to jail.
February 7-21, 2001	Ms. Wilkerson remains in jail. On 21 February, she pleads guilty to the charges against her and is sentenced to time served. She is then released and returned to her residence.

March 1, 2001	Ms. Wilkerson calls 911, stating that she had been betrayed by her case manager and that people had been sticking pins in her.
March 22, 2001	At a Medicine Check/Psychiatric Examination, her doctor indicates that Ms. Wilkerson's diagnosis and focus of her treatment is 295.30 (Schizophrenia, Paranoid Type). He indicates that Ms. Wilkerson complained of auditory hallucinations ("angel voices" saying either pleasant things or telling her she will die). The doctor states that she was having "classic panic attacks." He prescribes Ativan to combat the panic attacks and continues her Haldol and Cogentin prescriptions.
April 17, 2001	Ms. Wilkerson complains of side effects from her medication. Her case manager states, in her case note, "These behaviors are typical of Theresa and she is easily redirected."
April 18, 2001	At her quarterly Mental Health Division Service Reauthorization, CRP staff indicates Ms. Wilkerson's working diagnosis is 295.70 (Schizoaffective Disorder, Bipolar Type). CRP staff states, "She is taking Cogentin and Ativan has been added. Theresa is compliant with her medication and appears to be stable although she conts to voice numerous somatic complaints. She is not exhibiting any psychotic symptoms nor any side effects." Under the section entitled "Current identified need for Services," CVCSB states that Ms. Wilkerson "conts to need an intensive level of services [and] support to promote medication and prevent rehospitalization."
April 19, 2001	At a Medicine Check/Psychiatric Examination, her doctor indicates that Ms. Wilkerson's diagnosis and focus of treatment is 295.3 (Schizophrenia, Paranoid Type). He indicates that Ms. Wilkerson has auditory hallucinations. The doctor continues her medications.
April 19, 2001	Ms. Wilkerson's case manager states, in her case note, that Ms. Wilkerson "conts to voice numerous complaints re: meds, symptoms, housing… but this is typical of her."

April 30, 2001	Ms. Wilkerson's case manager states, in her case note, that she "conts to complain of symptoms, but appears to be at her baseline. Client continues to state that she would like to move to an adult home –wants to pursue this at the end of June."
May 5, 2001	Ms. Wilkerson calls CRP staff stating she is hearing voices and requests to go to the hospital. Her caseworker states, in her case note, that she "encouraged her to speak with the case manager on Monday and discuss her concerns."
May 6, 2001	Ms. Wilkerson tells CRP staff that she is hearing voices and requests to go to the hospital. Her case worker states, in her case note, that she "spoke [with] Theresa and encouraged her to take her meds as [prescribed] to assist with decreasing [auditory hallucinations]."
May 7-18, 2001	Ms. Wilkerson's caseworker states, in her case note, that Ms. Wilkerson "conts to report numerous somatic complaints but appears to be at baseline."
May 20, 2001	Ms. Wilkerson's case manager, in her case note, states that she encouraged Ms. Wilkerson "to take her psychotropic meds to assist in [decreasing her auditory hallucinations]." Ms. Wilkerson refused to take the medications, stating that she felt too weak to do so.
May 28, 2001	Ms. Wilkerson complains of anxiety attacks and that she feels weak.
May 30, 2001	Ms. Wilkerson's case worker states, in her case note, "Theresa has made several requests to go to the [Lynchburg General Hospital Emergency Room] this week but has not made any phone calls to 911 this week."
May 31, 2001	Ms. Wilkerson complains of anxiety attacks.
June 1, 2001	Ms. Wilkerson complains of anxiety attacks and requests more Ativan.
June 2-4, 2001	Ms. Wilkerson requests Ativan each morning in order to prevent "anxiety attacks." She asks that CRP staff call her doctor to prescribe more Ativan. Her caseworker states, in

	her case note, "Theresa could not describe any symptoms she was experiencing at the time. Throughout the weekend, Theresa appeared stable, functioning at baseline, despite her constant complaints of feeling 'weak' or experiencing anxiety."
June 5, 2001	Ms. Wilkerson requests Ativan to combat anxiety attacks.
June 1, 2001	Ms. Wilkerson calls 911 and is taken to the hospital. Lynchburg General Hospital conducted a mental health evaluation in which the doctor states that Ms. Wilkerson called 911 "saying that she was having a great deal of difficulty breathing and was quite anxious. Also stated that her heart was hurting and that she was not sure whether it was anxiety or a heart attack." When she arrives at the hospital, she tells the doctor that she wants to be committed to Western State Hospital. The doctor diagnosed her as having "Paranoid Schizophrenia." His recommendation states "We have seen the patient many times and her behavior today is basically her normal baseline behavior....In addition, the Census Reduction Team that works with the patient is requesting that she not be hospitalized as they feel they can manage her on an outpatient basis." Ms. Wilkerson's case manager states, in her case note, that she encouraged Ms. Wilkerson "to get some rest and calm herself down."
June 15, 2001	Ms. Wilkerson calls 911 and is taken to the hospital. Her case manager states, in her case note, that Ms. Wilkerson was "requesting to go to the hospital (psych) but not meeting criteria." She then "Discussed ways to handle anxiety and encouraged her to call [case manager] instead of 911."
July 4, 2001	Ms. Wilkerson tells CRP staff that she hears "voices." Her caseworker states that she was functioning at baseline and not showing any "acute symptoms."
July 4, 2001	After her caseworker leaves, Ms. Wilkerson calls 911, stating that she is hearing voices. Her caseworker states, in her case note, "When [Ms. Wilkerson] arrived, she admitted to lying to get to the hospital. She stated that her [case worker] had betrayed her and she wanted the ER to assist in finding alternative placement." In the section entitled "Relevant Medical/Psychological History" her caseworker writes

	"History of calling 911 inappropriately and manipulating staff to get to the hospital." In the section entitled "Description of crisis intervention activities provided by CVCS staff" she writes "Discussed severity and inappropriateness of Theresa's behaviors today. Informed Theresa of legal action that could occur due to her misuse of emergency services. Briefed [CVCSB home supervision staff] about Theresa's actions in case Theresa's behaviors continue through the evening."
July 7-8, 2001	Ms. Wilkerson calls CRP staff stating that she is hearing voices and requesting to go to the hospital. Her caseworker states, in her case notes, "When questioned about the content of hallucinations, Theresa could not 'remember' what the voices said. Theresa appeared functioning at baseline throughout the weekend."
July 16, 2001	Ms. Wilkerson's caseworker states, in her case note, "Theresa has been functioning at baseline though she constantly complains of somatic [symptoms]....In past 3 months, Theresa has called 911 and gone to [Lynchburg General Hospital] 3x. Each time she has not met criteria for psychiatric hospitalization.... Theresa is stable at this time despite her complaints which consist mostly of 'weakness' and rapid heart beat at times."
July 16, 2001	At her quarterly Mental Health Division Service Reauthorization, CRP staff indicates Ms. Wilkerson's working diagnosis is 295.70 (Schizoaffective Disorder, Bipolar Type). CRP staff states, "No changes have been made with Theresa's medication. She remains functioning at baseline....Theresa continued to contact emergency services for false complaints."
July 19, 2001	At her Medicine Check/Psychiatric Examination, her doctor notes that Ms. Wilkerson is experiencing confusion, change in concentration, weakness, delusional thoughts, and auditory hallucinations. He identifies her diagnosis and focus of treatment as 295.30 (Schizophrenia, Paranoid Type). He states "She continues to request med changes. She consistently wants to try atypicals but she has been stable on current regimen. Theresa does complain of [auditory hallucinations] at times but no significant behavioral changes.

	Calls 911, believes heart attacks occurring." The doctor does not make any changes to her medication.
July 25, 2001	Ms. Wilkerson complains of a rapid heartbeat. She sees a doctor who finds her heart rate and blood pressure to be normal. The doctor states, per case manager's case note, that Ms. Wilkerson should take Ativan "when she feels increased heart beat as it is probably anxiety."
August 4-5, 2001	Ms. Wilkerson states that she is feeling weak and states that she wants to change her medication. Her caseworker, in her case note, states that she "encouraged her to discuss it with Dr. Saturday afternoon. Theresa became agitated, stated she wanted to go to the hospital, threw trashcan across the room. When [caseworker] attempted to redirect her, she lay down on the couch and would not talk to [her]. Theresa's parents came in at this time to visit her. Theresa screamed, stated she was hallucinating and hearing voices 'I heard the Devil blow in my ear.' Theresa's parents did a great job of redirecting her and not falling in to her game playing."
August 7, 2001	In her case note, Ms. Wilkerson's case manager states that Ms. Wilkerson's parents contacted her, stating that Ms. Wilkerson had been calling them and "complaining about her meds, wanting to go to hosp....Assured them that [Ms. Wilkerson] is at her baseline."
August 13-17, 2001	In her case note, Ms. Wilkerson's case manager states that she "conts to report numerous somatic complaints."
August 22, 2001	Ms. Wilkerson goes to an appointment with her medical doctor. She voices "numerous somatic complaints."
August 26, 2001	At 4:00 P.M., Ms. Wilkerson becomes angry and throws the telephone across the room. She then leaves her residence and crossed the street. Ms. Wilkerson's caseworker followed her, attempting to convince her to return to the residence. Ms. Wilkerson then ran from the case worker. When her case worker realized that she could not catch up to Ms. Wilkerson, she returned to the residence to contact Ms. Wilkerson's case manager and the hospital Emergency Room. CRP staff contacted the Emergency Room staff to warn that they may be getting a call from Ms. Wilkerson. Ms. Wilkerson's case

> manager states, in her case note, that "tentative plan was to initiate a [temporary detention order] due to her behaviors and level of agitation." Ms. Wilkerson proceeded to the Rivermont Street Bridge and jumped to her death.

V. FINDINGS

It is the opinion of DRVD that Ms. Wilkerson was the victim of neglect by her community service and health care providers. The record of the case, and the report of Dr. Koshes, clearly support DRVD's finding that CVCSB did not create and/or implement an appropriate treatment plan for Ms. Wilkerson and that CVCSB and the doctors affiliated with CVCSB did not properly diagnose or treat Ms. Wilkerson's disability.

A. Definition of Neglect

The Protection and Advocacy for Individuals with Mental Illness Act defines "neglect" of a person with mental illness as

> [A] negligent act or omission by any individual responsible for providing services in a facility rendering care and treatment which caused or may have caused injury or death to a [*sic*] individual with mental illness or which placed a [*sic*] individual with mental illness at risk of injury or death, and includes an act or omission such as the failure to establish or carry out an appropriate individual program plan or treatment plan for a [*sic*] individual with mental illness the failure to provide adequate nutrition, clothing, or health care to a [*sic*] individual with mental illness, or the failure to provide a safe environment for a [*sic*] individual with mental illness, including the failure to maintain adequate numbers of appropriately trained staff.
> ***42 U.S.C. §10802(5)***

After studying the record of this case, conducting interviews with all parties involved, and retaining and reviewing the report of Dr. Koshes, DRVD finds that CVCSB

committed neglect in that it failed to properly establish and/or carry out an appropriate treatment plan for Ms. Wilkerson.

B. CVCSB Failed to Establish or Carry Out an Appropriate Treatment Plan for Ms. Wilkerson

CVCSB failed to establish and/or implement an appropriate treatment plan for Ms. Wilkerson, leading to CVCSB and the doctors affiliated with CVCSB ("CVCSB's doctors") failing to properly diagnose or treat Ms. Wilkerson's disabilities. These failures occurred in two distinct respects: First, CVCSB and CVCSB's doctors failed to properly treat Ms. Wilkerson's Schizoaffective Disorder. Secondly, CVCSB failed to address, or account for in its treatment, Ms. Wilkerson's limited cognitive functioning.

1. CVCSB Failed to Treat Ms. Wilkerson's Schizoaffective Disorder

Throughout Ms. Wilkerson's 16 months in the CRP, CVCSB identified her working diagnosis and, thus, the focus of her treatment, as Schizoaffective Disorder.[2] Nevertheless, CRP staff either did not recognize her behaviors, which were common to persons with Schizoaffective Disorder, as symptoms of her disability or determined that her behaviors were false and manipulative. As a result, CVCSB did not address or seek to treat the behavioral symptoms of her Schizoaffective Disorder. Furthermore, CVCSB's doctors treated Ms. Wilkerson under an, incorrect, diagnosis of Schizophrenia, Paranoid Type. This incorrect diagnosis resulted in a failure to recognize that Ms. Wilkerson exhibited symptoms of her Schizoaffective Disorder and prevented them from

[2] After reviewing her records, Dr. Koshes also concluded that, based upon her symptoms, Ms. Wilkerson had Schizoaffective Disorder.

treating those symptoms or prescribing medications that could have addressed and treated those symptoms.

a. Symptomology and Treatment of Schizoaffective Disorder

Schizoaffective Disorder is a severe mental illness that displays the symptoms of both Schizophrenia and mood disorders. People with Schizoaffective Disorder display psychotic symptoms such as delusions, hallucinations, disorganized thinking, agitation, social withdrawal, and apathy and affective symptoms such as extreme mood swings, thoughts of death or suicide, and acute psychosis.

Ms. Wilkerson was diagnosed with Schizoaffective Disorder, Bipolar Type. This diagnosis is most frequently accompanied with manic episodes such as elation, euphoria, or extreme irritability.

Studies have shown that persons with Schizoaffective Disorder are best treated with antipsychotic medications. The group of medications known as "atypical antipsychotics" have, in general, proven to be most effective. Antidepressent medications have also proven valuable to treat the affective and depressant symptoms of Schizoaffective Disorder. See, generally, Levinson and Umapathy, Treatment of Schizoaffective Disorder and Schizophrenia with Mood Symptoms, Am J. Psychiatry, August 1999. See, also, The Merck Manual of Diagnosis and Therapy, Section 15, Chapter 193 ("For treatment of the bipolar (manic) type, antipsychotics combined with lithium may be more effective than antipsychotics alone. . . The new [i.e. atypical] antipsychotics may be more effective than the conventional ones.").

b. CVCSB Failed to Treat Ms. Wilkerson's Schizoaffective Disorder

As mentioned, above, there is no doubt that CVCSB considered Ms. Wilkerson to have Schizoaffective Disorder, Bipolar Type. From Ms. Wilkerson's first Individualized Service Plan in April of 2000, to each of her CVCSB Mental Health Service Reauthorizations (conducted on July 24 and October 23, 2001 and January 22, April 18, and July 16, 2001) her working diagnosis remained Schizoaffective Disorder, Bipolar Type.

Given that CVCSB was well aware of Ms. Wilkerson's mental illness, it is particularly troubling that CVCSB staff considered behaviors that are recognized as being symptoms of Schizoaffective Disorder to be false or attempts to manipulate CRP staff. For example, Ms. Wilkerson consistently displayed psychotic symptoms including auditory hallucinations (reported in CVCSB case notes on August 7, November 6 and 10, 2001 and January 3 and 9, March 22, May 6, July 4, 7, and 16, August 5, 2001), delusional thoughts (reported in CVCSB case notes on June 26, December 28, 2000, January 1 and 9, and August 5, 2001), and extreme agitation (reported in CVCSB case notes on June 26, 2000, January 9 and 29, February 3, 4, 5, and 6, and August 5, 2001). She also repeatedly displayed affective symptoms including suicidal thoughts (reported in CVCSB case notes on April 28, July 11, August 7, September 4, 17, and 29, and November 6, 2000, January 4, February 6, 2001) and increased goal-oriented behavior (including attempts to secure a new residence reported, for example, in CVCSB case notes on June 3, 6, and 27, July 25 and 26, August 4, 14, 15-17, 22-25, and 30,

September 5, 18, 20, and October 2, 2001, or new medications, reported, for example, in CVCSB case notes on April 5, 17, 19, and 22, June 22, July 9, 16, 19, 20, and 23, August 3, 7, 10, 13, and 26, 2001).

However, when confronted with Ms. Wilkerson's behavioral symptoms, CVCSB personnel either did not recognize them as symptoms or dismissed them as false or manipulative (reported in CVCSB case notes of November 6, December 20 and 28, 2000, January 4 and 7, February 5, April 17-19, June 4 and 11, July 4, 8, and 6, and August 5, 2001). For example, on December 28, 2000, Ms. Wilkerson complained to her case manager that someone had gotten a key to her room and was coming in to stick her with pins. Rather than see this as a delusion and a symptom of Ms. Wilkerson's Schizoaffective Disorder (and realizing that she had the same delusion on December 20), her case manager stated, in her case note, "Cl is seeking attention and this is typical behavior when she does not get what she wants." On January 1, 2001, she would, again, have the delusion that someone was sticking her with pins. That time, she called 911 and was taken to the hospital.

Similarly, on January 4, 2001, Ms. Wilkerson called 91 and stated that someone had scratched her. Her case manager stated, in her case note, "CM feels this is all for attention on Cl's part." Another incident occurred on February 5, 2001 when, in the words of her caseworker, Ms. Wilkerson's "anger began to escalate." Ms. Wilkerson attempted to attack her roommate, stating "I'll kill you next time." After her roommate called the police, the caseworker told the responding officer that Ms. Wilkerson did not require a mental health consultation because she was not exhibiting any psychotic

symptoms. In both of those cases, clear symptoms of Schizoaffective Disorder delusions and extreme agitation – were discounted either as attention-seeking behavior or as nonsymptomatic behavior.

In interviews, Ms. Wilkerson's case manager and case workers uniformly stated that Ms. Wilkerson's behaviors were attention-seeking rather than symptoms of her mental illness. All of her caseworkers stated that her behaviors were attempts to manipulate staff into returning her to the hospital. One case worker stated that she believed Ms. Wilkerson's suicide itself to be attention-seeking, reasoning that Ms. Wilkerson believed that she had to "do something" to back up her quest for attention. Another case worker stated that Ms. Wilkerson's "ultimate goal in life was to get back to the hospital." She also stated that she never believed that Ms. Wilkerson was suicidal stating, that she was "anxious or depressed, but never suicidal." She concluded that Ms. Wilkerson jumped off of the Rivermont Street Bridge in an attempt to injure, but not kill, herself so that she would be returned to the hospital. Her case manager was adamant, stating that Ms. Wilkerson only stated suicidal ideations or "acted out" in an attempt to return to the hospital, stating "She liked the hospital. The nurses liked her. She liked the attention."

Ms. Wilkerson's caseworkers and case manager also described Ms. Wilkerson's episodes of severe mood swings and extreme agitation (described by them as "tantrums") as being behavioral choices rather than symptoms of her mental illness. Her case manager stated that, when Ms. Wilkerson did not get what she wanted she'd "yell, scream and go to her room." One case worker related a "tantrum," which occurred three

weeks before Ms. Wilkerson's suicide. On that date, August 4, 2001, Ms. Wilkerson became agitated, threw a trashcan across her room and then lay down on a couch and would not respond to the case worker. At that time, Ms. Wilkerson's parents came into the room. Ms. Wilkerson then began to scream that she needed to go to the hospital and was hearing voices. The caseworker described this "tantrum" as "a little show for Mom and Dad" and, in her case note, described Ms. Wilkerson's behavior as "game playing.

In addition, doctors affiliated with CVCSB either misconstrued or discounted Ms. Wilkerson's behavioral symptoms. CVCSB's records are replete with requests by Ms. Wilkerson to have her medication changed (noted in CVCSB case notes of April 5, 7, 19, and 22, June 22, July 9, 16, 19, 20, and 23, August 3, 7, 10, 13, and 26, 2001). Despite her requests, and despite her showing symptoms of her Schizoaffective Disorder such as auditory hallucinations, problems concentrating, and weakness (all noted in Psychiatric Examination reports of August 7, November 6, 2000, March 22, April 19, and July 19, 2001), CVCSB doctors never sought to treat her with atypical antipsychotic medication or with an antidepressant.[3] Instead, CVCSB's doctors, like CRP staff, seemed either not to recognize her behaviors as symptoms of her mental illness or to discount her symptoms as voluntary behaviors. For example, on November 6, 2000, after Ms. Wilkerson indicated that she was experiencing drowsiness, memory loss, fatigue, auditory hallucinations, and suicidal thoughts, her psychiatrist stated that Ms. Wilkerson, "always has some complaint and continues to say she feels 'weak." Similarly, on July

[3] As will be further set forth, below, CVCSB's doctors either did not recognize or realize that Ms. Wilkerson had Schizoaffective Disorder. In the reports of her Medicine Check/Psychiatric Examinations, her diagnosis is referred to as "Schizophrenia, Paranoid Type."

19, 2001, CVCSB's psychiatrist noted that Ms. Wilkerson was experiencing confusion, change in concentration, weakness, delusional thoughts, and auditory hallucinations. The psychiatrist stated that Ms. Wilkerson "consistently wants to try atypicals but she has been stable on her current regimen."

It is the opinion of DRVD that Ms. Wilkerson was, in the instances described above and in several similar instances set forth in the chronology, displaying symptoms of her Schizoaffective Disorder. However, CVCSB staff and CVCSB's doctors failed to recognize them as symptoms of her Schizoaffective Disorder or mistakenly considered those symptoms to be false, manipulative, and attention seeking. As a result, those symptoms, and her disability, were either missed or discounted instead of treated. Because the symptoms were considered to be false, or because they did not recognized them as symptoms, CVCSB and CVCSB's doctors did not seek to use atypical antipsychotic or antidepressant medication to address or control her behavioral symptoms and did not attempt any other ways, such as through education or therapy, to address or treat those symptoms.

The failure of CVCSB and CVCSB's doctors to recognize the symptoms of Ms. Wilkerson's Schizoaffective Disorder led to Dr. Koshes' conclusion that Ms. Wilkerson's "sad death was the product of the treatment team's inability to recognize the degree of distress this patient was in and their reliance on the theory that her behaviors was [*sic*] based on manipulation in the service of her dependency needs." Specifically, he states that her panic and anxiety attacks (which are noted in Ms. Wilkerson's Medicine Check/Psychiatric Evaluations on August 7 and November 6, 2000, March 22 and 19

July, 2001, and in CVCSB case notes on May 28, June 1-2, 5 and 15, July 16 and 25, and August 5, 2001) could and should have been treated with an antidepressant of the selective serontonin reuptake inhibitor ("SSRN") class. Dr. Koshes specifically states "The standard of care in July 2001 [when Ms. Wilkerson specifically requested that she be treated with an atypical antipsychotic medication]:

> would have been to...treat [her] panic with an SSRI (a medication which was reported to be effective in her care in the past), and change the patient to an atypical antipsychotic for improved symptom management. Many of her behaviors, which appeared manipulative, could have been explained by panic and anxiety; consider the frequent ER visits and impulsive, agitated behaviors when frustrated. The standard of care, once panic attacks were diagnosed, would have been to evaluate the patient for the use of an SSRI. Even if her psychiatrist had noted that there was a diagnosis of Schizoaffective Disorder, Bipolar Type[4], it would have been appropriate to consider a mood stabilizer or antidepressant, which would have also helped with impulsivity.

A review of this case leads to the inescapable conclusion that Ms. Wilkerson was trapped in a "vicious cycle." The symptoms of her disability could have, if they had been recognized or taken seriously, been treated with appropriate medication, which may have ameliorated the symptoms. However, because CVCSB staff and doctors either did not recognize her symptoms or saw them as false and manipulative behaviors, Ms. Wilkerson did not receive any treatment for them, which resulted in her having more such symptoms, which only furthered CVCSB's conclusion that she was being false and manipulative.

[4] As more fully set forth, below, the psychiatrist mistakenly noted her diagnosis to be Schizophrenia, Paranoid Type. This diagnosis conflicted with the diagnosis used by CVCSB. Dr. Koshes, upon reviewing Ms. Wilkerson's records, came to the conclusion that Ms. Wilkerson had Schizoaffective Disorder.

The failure to provide Ms. Wilkerson with appropriate treatment and medication points to another, perhaps larger, problem: there was, in Dr. Koshes' words, "a major dis-connection in the treatment team regarding the presence of an affective component of her illness." Put simply, CVCSB's CRP staff persons and doctors operated under different working diagnoses of Ms. Wilkerson's mental illness. In all of Ms. Wilkerson's CVCSB Mental Health Service Reauthorizations (conducted on July 24 and October 23, 2001 and January 22, April 18, and July 16, 2001) her diagnosis was noted as Schizoaffective Disorder, Bipolar Type. However, in her Medicine Checks/Psychiatric Examinations, her treating psychiatrists noted her diagnosis to be Schizophrenia, Paranoid Type.

The problem with such inconsistent diagnoses is clear: different mental illnesses are treated differently. In this case, Schizophrenia, Paranoid Type, is not normally treated with antidepressants. Thus, because her psychiatrists operated under incorrect, assumption that Ms. Wilkerson did not have Schizoaffective Disorder, they were unlikely to prescribe medication to treat behaviors that were symptomatic of a disability they did not know she had.[5] Because CVCSB's doctors did not know, or did not recognize, that Ms. Wilkerson had Schizoaffective Disorder, they were more likely to determine, like CRP staff workers, that Ms. Wilkerson's behaviors, which indicative of a person with Schizoaffective Disorder (and not necessarily of someone with Schizophrenia, Paranoid Type) were false rather than symptomatic. Had her

[5] One of Ms. Wilkerson's psychiatrists stated that his diagnosis of her as having Schizophrenia, Paranoid Type was "carried forward," meaning, not based upon his independent analysis. Again, this represents a terrible dis-connection between CVCSB and its doctors in that Ms. Wilkerson's psychiatrists "carried forward," throughout her treatment, an incorrect diagnosis.

psychiatrists recognized the affective part of her disability, they could have prescribed antidepressant medication, as recommended by medical sources.

In sum, in Dr. Koshes' words, "Had the entire treatment team understood the nature of her symptoms and her significant distress which appeared throughout the clinical record, and had a unified treatment plan based upon an agreed-upon diagnosis, her untimely death may have been prevented." Instead, Ms. Wilkerson's treatment team operated under different diagnoses, if not at cross-purposes, and under the false impression that her reports of suicidality, anxiety, and depression and her reports and displays of delusions, auditory hallucinations, and violent mood swings either were not symptoms of Schizoaffective Disorder or were false and manipulative behaviors.

Based on the foregoing, it is the opinion of DRVD that Ms. Wilkerson was the victim of neglect because CVCSB's failed to establish and/or carry out an appropriate treatment plan for Ms. Wilkerson's Schizoaffective Disorder.

c. CVCSB Failed to Address or Account for Ms. Wilkerson's Cognitive Impairment

In addition, CVCSB did not adequately account for or address Ms. Wilkerson's cognitive impairment. Prior to her participation in the CRP, Ms. Wilkerson had received several diagnoses indicating that she had a cognitive impairment. These diagnoses ranged from Mental Retardation to Borderline Intellectual Functioning. Dr. Koshes, upon reviewing Ms. Wilkerson's records, concluded that she had "at the least, Borderline Intellectual Functioning."

Despite Ms. Wilkerson's cognitive impairment (and historical diagnosis of having such an impairment), her treatment plan did not address or make any consideration for her impairment. In his report, Dr. Koshes states "Modifications in the treatment plan and approach to the patient's adaptation in the community based on the patient's level of understanding should have been made." Dr. Koshes further posits that Ms. Wilkerson's "inability to conform to her medication regimen during her care and perhaps her difficulties in expressing her needs and desires appropriately may have been a function of her cognitive capacity."

CVCSB did not make any allowances for or mention of Ms. Wilkerson's cognitive impairment in her treatment plan. CVCSB was well aware of her cognitive impairment. In an interview, Ms. Wilkerson's mother stated that she made CVCSB aware of her daughter's cognitive deficit and requested services for her. She states that she was told that her daughter's "mental illness over-rides her mental retardation" and, thus, she would receive services from CVCSB's mental health staff rather than its mental retardation staff. Thus, it is clear that CVCSB was aware of Ms. Wilkerson's cognitive impairment and should have made allowances in her treatment plan for it. For example, CVCSB could have used specialized educational techniques such as repetition or modified tasking approaches to help Ms. Wilkerson better understand her disability and symptoms and remain compliant with her medication regimen.

Based on the foregoing, it is the opinion of DRVD that Ms. Wilkerson was the victim of neglect because CVCSB failed to establish or carry out an appropriate treatment

plan for Ms. Wilkerson's Schizoaffective Disorder, taking into account her cognitive impairment.

VI. CONCLUSION

In the historic case of Olmstead v. L.C., the United States Supreme Court held "the unjustified institutional isolation of persons with disabilities is discrimination."[6] The Olmstead case stands firmly for the proposition that persons with disabilities who are capable of living in community placements, rather than in institutions, should be empowered and encouraged to do so. In furtherance of the principles set forth in Olmstead, CVCSB's Census Reduction Program aims to lessen the number of persons who must live, unnecessarily, in institutions and provide community placements to persons who are capable of living in them. Clearly, CVCSB's goal is a worthy one and should be pursued.

However, it is equally clear that a community placement, no matter how well intentioned, that does not provide adequate supports and services for a person with a disability, tailored to that person's specific symptomology, is doomed to fail. Because CVCSB did not prepare and/or carry out an adequate treatment plan for her, Ms. Wilkerson's placement was so doomed.

It is the opinion of DRVD that, in Ms. Wilkerson's case, CVCSB, with the best of intentions and with the goal of helping her live in the community, created a placement for Ms. Wilkerson with but one goal: keep her out of the hospital (as stated in the initial

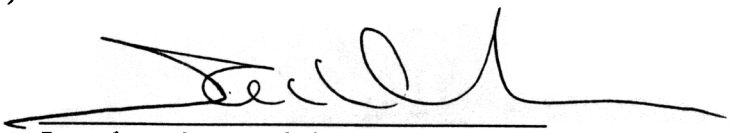
[6] Olmstead v. L.C. *ex rel* Zimring, 119 S.Ct. 2176, 2187 (1999).

CVCSB case note, dated May 29, 2000, "G - To remain living independently with support of staff and free of hospitalization."). This overarching aim seems to have colored all of CVCSB's dealings with Ms. Wilkerson resulting in the CRP staff either misunderstanding that her behaviors were symptoms of her disability that might require hospitalization or misconstruing her symptoms as false and manipulative. As a result, Ms. Wilkerson's disability, the very thing that CVCSB intended to treat, went untreated.

This case presents a painful irony: that Ms. Wilkerson's CRP staff, who so obviously cared so deeply about her, could have neglected her. Unfortunately, the unavoidable truth of this matter is that Ms. Wilkerson was the victim of neglect. While it is not the place of this report to state, conclusively, that CVCSB's neglect was the proximate cause of her death, it is undeniable that, with proper treatment, including medication, Ms. Wilkerson's symptomology could have been lessened, which may have prevented her death.

Dated: May 1, 2002

Respectfully Submitted
Commonwealth of Virginia
Department for Rights of Virginians with Disabilities
202 N. 9th Street, 9th Floor
Richmond, VA 23219
(804) 225-2041

By: 

Jonathan G. Martinis
Managing Attorney, PAIMI Program

EXHIBIT A

RONALD J. KOSHES, M.D.
Diplomate of the American Board of Psychiatry and Neurology

1348 East Capitol Street, N.E.
Washington, D.C. 20003
(202) 543-0406

REVIEW OF CLINICAL RECORDS AND CARE

For
The Commonwealth of Virginia
Department for Rights of Virginians with Disabilities

RE: Teresa Wilkerson
D.O.D.: August 26, 2001
D.O.B: September 23, 1952
S.S.N.: 223-68-7276

IDENTIFYING INFORMATION: The deceased was a 41 year old, Caucasian female residing in Virginia and receiving outpatient psychiatric treatment at a Community Service Board, and enrolled with a census reduction program at the time of her death on August 26, 2001. The medical records were referred to the undersigned on or about January 15, 2002, by Jonathan G. Martinis, Esq., Managing Attorney and Ms. Heidi Lawyer, Acting Director, of the Commonwealth of Virginia, Department for Rights of Virginians with Disabilities, for assistance in the investigation of whether the deceased's treatment met standards of psychiatric care.

A professional services agreement dated January 15, 2002 by Ms. Lawyer delineated the scope of services to be performed by an expert reviewer. Clinical records and correspondence delineated below were provided by the Department for Rights of Virginians with Disabilities for

review.

DISCLOSURE: Before engaging in a review of the clinical records, it was made clear to the representatives of the Department for Rights of Virginians with Disabilities, that a review of the records would be undertaken in a non-biased and scientific manner. Documentation of clinical management of Ms. Wilkerson would be the critical source of information on which an independent judgement of clinical appropriateness and standard of care would be made. Additional information would be obtained from the Department for Rights of Virginians with Disabilities, Ms. Wilkerson's treating psychiatrist at the time of her death, other selected clinical staff, and the decedent's mother in a telephonic interview. The Department for Rights of Virginians with Disabilities was not to assume that the reviewer had any bias in his task and that rendering a sound scientific opinion in the aforementioned case was the principle goal. The Department for Rights of Virginians with Disabilities was to understand that an earnest attempt would be undertaken to determine the relevant patient care issues in the death of Teresa Wilkerson. Attention would be paid by the reviewer to the commonly accepted standards of psychiatric care as emulated in peer-reviewed professional publications. Where important, references would be provided.

Having understood the stipulations of the review, the Department for Rights of Virginians with Disabilities, through its agents, agreed to commence the clinical review.

SUMMARY OF FINDINGS: Based on a review of the available clinical records and information provided by the Department for Rights of Virginians with Disabilities, the documented evidence indicated that Teresa Wilkerson's care was not appropriate and that her death could have been prevented. Her death resulted, in substantial part, from a failure of the treating personnel to recognize the cognitive impairments of the patient and the affective component of her illness. To wit:

1 There was evidence in the clinical record which indicated a significant past history of both cognitive dysfunction and affective illness which would have necessitated a modification in the treatment planning for this patient. This modification would have involved the treatment team approach as well as the medications used to treat her illness.

2. The treatment goals included restriction of services without a clear therapeutic benefit. This restriction of services was based on the faulty assumption that Ms. Wilkerson's behaviors around hospitalization were manipulative, and the inability of the CSB to provide adequate services for this impaired individual. This resulted in the failure to provide an adequate level of care.

The conclusion reached in this review of the clinical records is that failure to recognize cognitive impairment and treat an affective component of her illness, combined with a restriction in the application of appropriate level of care, contributed significantly to the death of Ms. Wilkerson.

HISTORY OF THE ILLNESS AND INCIDENT: The records available for review of the Teresa Wilkerson case were as follows:

Psychological Autopsy;
Central Virginia Community Service Board notes, financial records, and treatment plans;
Various hospital discharge and admission notes from Lynchburg General, SMVI, and other hospitals;
Historical notes from 1987 until the time of her death from the Central Virginia Community Service Board;
Telephonic interview with the decedent's mother, Dr. , Dr.

Ms. [redacted] and

Other documentation provided by the Department for Rights of Virginians with Disabilities.

At the time of her death, Teresa Wilkerson was a psychiatric patient enrolled in an intensive case management service which provided care to high-risk patients in the community. The program was administered by the CSB (Community Services Board) in the area in which she was residing. She was living in a supervised apartment and taking medications on a supervised basis. She was part of a census reduction program which was aimed at keeping patients in the community and out of the hospital.

Prior to her death, Ms. Wilkerson had an extensive psychiatric history. The earliest medical records from a hospitalization in July of 1987 indicated that her treatment had been "helpful with depression and anxiety." A diagnosis of Schizoaffective Disorder was made, and no mention of cognitive dysfunction was present in the medical record. Mixed Personality Disorder was also diagnosed based on dependency defenses which were displayed, and traits of Borderline Personality Disorder were also described. On a group home application in January of 1989, her diagnosis appeared as Schizophrenia and Mild Mental Retardation. In February of 1989 a residential checklist noted that Ms. Wilkerson needed frequent verbal prompting for tasks and indicated that this might be a sign of mental retardation. Staff noted that she was compliant with her medications.

In June of 1990, Ms. Wilkerson was hospitalized for suicidal behavior and the discharge summary indicated that she had Mental Retardation, a Major Depressive Episode, and Psychosis, Not Otherwise Specified. Slightly over one year later, in July of 1991, she was given the diagnosis of Schizophrenia, and no diagnosis Mental Retardation or mention of cognitive difficulties was made. One month later, a social worker noted her "mental retardation" in a clinical record. Throughout her hospitalizations, attempts would be made to house Ms. Wilkerson in the community. These placements would last several months and Ms. Wilkerson

would grow homesick and leave the community setting to return home to her parents' household. She was accepted by her parents and would become non-compliant with medications, or become frustrated with her living situation.

The medications Ms. Wilkerson were prescribed during her illness were generally of the antipsychotic class. Often, as noted in the clinical records, Ms. Wilkerson would report side-effects of slowness and sedation which were troublesome. She would frequently indicate to her treatment team that she was anxious.

In December of 1992, she suffered a panic attack and was hospitalized. The diagnosis of Mental Retardation was again dropped from her diagnosis list. Ms. Wilkerson was reporting sedation while taking haloperidol and was drinking three to four cups of coffee a day in order to stay awake. It was during this time that she was placed on Prozac for her affective symptoms. She reported that this medication had helped ("Prozac helped."). In January 1993 she was hospitalized for anxiety and give clonazepam; she reported depressive symptoms and staff noted depression in their assessments, but no antidepressant was prescribed. Dr. , assigned to her case at the time, noted trichotillomania, an anxiety condition. This behavior is never mentioned again in any of the medical records.

In December of 1993 she was admitted to Western State Hospital and personality testing revealed that the patient had "less than average intelligence." Anxiety and obsessive symptoms were prominent and the patient was given a diagnosis of Schizoaffective Disorder. During a hospitalization in May of 1994, the nursing assessment noted that the patient reported "nervousness since 1971." Mental Retardation was not given as a diagnosis, however, "Schizoaffective" was retained. It is important to note that when cognitive problems were noted by staff or other evaluators, both in or out of the hospital, no accommodations such as specialized patient education, or repetition, modified tasking approached were documented in the treatment plans.

In June of 1994, she was given a diagnosis of Schizophrenia during a hospitalization and "borderline intellectual functioning" was noted in the medical record. Most of her hospitalizations up to this point and continuing into the last years of her life were for agitation and suicidal ideation. She was essentially hospitalized for safety. Her behaviors appeared from the clinical records to be impulsive and followed a pattern of anxiety and frustration with services, staff, etc.

In January 1995, Ms. her caseworker, wrote to the Mental Retardation and Developmental Disabilities Administration pursuing eligibility for case management services based on Ms. Wilkerson's mental retardation. of this agency, wrote back indicating that mental retardation was not present. There was no IQ testing or other psychological testing performed. Ms. Wilkerson's father was not in agreement with this finding and indicated that his daughter had always "been a slow learner." He wanted to appeal the decision which denied the case management services.

She was hospitalized in June of 1995 and diagnosed with "Schizoaffective Disorder," and during this time was prescribed Clozaril. She was noted to be "stable," until November of 1996, when she was taken off this medication and placed on a conventional antipsychotic agent.

Her hospitalizations increased in frequency during the next few years. In December of 1996, she was suicidal and hospitalized. In March of 1997, she was diagnosed with "Schizoaffective Disorder," and again hospitalized in October that year until March of 1998 with a diagnosis of "Schizoaffective Disorder and Obsessive Compulsive Disorder." She was hospitalized in March of 1999 for depression and suicidality, again in April of that year for suicidal ideation with a plan, depression, and anxiety. She was given the diagnosis of Schizoaffective in July of 1999 following a hospitalization, and one month later, was given the diagnosis of Schizophrenia as an outpatient.

In September of 1999, she was hospitalized and given the diagnosis of Schizoaffective

Disorder. She was discharged in April 2000 to live at a supervised apartment, with intensive case management through the CSB and was part of a census reduction program.

At the end of April of 2000, she was hospitalized at Lynchburg General Hospital with suicidality and anxiety. She was returned to the community, shortly thereafter. Dr. who had seen Ms. Wilkerson "many times" in the hospital noted that she was a patient who was frequently admitted in crisis from the community. He said: "The staff knew her and she knew the staff well." He was aware of her cognitive problems and the affective component of her illness and felt that it was a significant component of the presentation of her illness when hospitalized. Dr. also noted that when directed not to admit patients into his hospital from Lynchburg (these patients would be served in a different area), it was "probably and adjustment for Teresa.

Her records resume for review in July 2000 when she was living in supervised housing. Her care was through the local CSB. She complained about tiredness and weakness, and the side-effects of her medications. Until her death, she had a series of three psychiatrists assigned to her case.

In November 2000, she was diagnosed with panic attacks and given Paxil. She was taking this medication and reported to be doing well. In January, 2001, she was hospitalized for violence and impulsivity and the Paxil was discontinued. The hospital records available for review, do not provide an explanation why the medication was discontinued. She, however, was given the diagnosis of Schizoaffective Disorder. The symptoms of impulsivity and aggression were treated with an antipsychotic agent of the conventional class. No assessment for the use of a mood stabilizer, or anticonvulsant for aggression and impulsivity was documented in the chart.

On March 22, 2001, Ms. Wilkerson met with her psychiatrist (Dr. for medication management. His note indicated that she was suffering from "classic panic attacks," and he began Ativan for this reason. No mention of therapy with a selective serotonin reuptake

inhibitor was made. Dr. indicated in his note that she was being treated for Schizophrenia, Paranoid type. This diagnosis was seen in the documentation of subsequent visits. The treatment plan, however indicated that the diagnosis which was the primary focus of treatment was Schizoaffective Disorder.

In a telephonic interview on February 27, 2002, Dr. , stated that he had seen Ms. Wilkerson two or three times. He saw her for twenty minutes to one-half hour for each visit. Dr. said that while at the CSB, his only job was "to write prescriptions." He noted that Ms. Wilkerson was "intrusive, living in a group home, and she had a good case manager." He reported that he received no subtle or overt pressure to keep Ms. Wilkerson out of the hospital, but that overall, he felt the level of outpatient support for patients as impaired as Ms. Wilkerson was poor. He said: "The CSB didn't have funding for taking care of this type of acuity in the community." He said, that Ms. Wilkerson "should have remained in the hospital indefinitely; a group home was not the best thing for her; the level of care for Teresa should have been in the hospital." It is important to note that Dr. , did not feel that there was any acute issue with Teresa at the time of her death, he was speaking about her level of care in general and did make some comments about the level of care for other patients. He said: "about five percent of the patients assigned to him should be treated in levels of higher acuity. If it were my family, I would have them treated somewhere else, and I would pay for it." Dr. noted that there was a weekly case conference for patients who were having more acute crises and that Ms. Wilkerson "never came up for review." He also said that he "carried forward" the diagnosis of Schizophrenia, that the diagnosis "seemed realistic." He was not aware of any diagnosis of impaired cognition or suspected mental retardation, or learning disabilities. He said: "I did not know her well enough to make that diagnosis." Dr. did not think that Ms. Wilkerson was a good candidate for atypical antipsychotic agents because of compliance issues.

Ms. called the undersigned on February 27, 2002, following the conversation with Dr. and offered to provide any information which might be helpful. She, at the time of this writing, is the Director of Adult and Family Services for the CSB to

which Ms. Wilkerson was assigned. She related that Ms. Wilkerson was a difficult client and she felt that the CSB did not apply any pressure to the treatment teams to limit hospitalizations. She stated that the Medical Director, Dr. would be contacting the undersigned to provide additional information. At the time of the submission of this report, Dr. had not contacted the undersigned. If additional information is provided, it will be supplied in an addendum to this report.

Throughout the Spring of 2001 there is clinical documentation of Ms. Wilkerson's interest in changing her medications. Ms. Wilkerson was concerned with the side-effects of her medication and she reported feeling that her medications were not working. She assaulted her room-mate and was put in jail for this during the Spring.

In June of 2001, she went to the Emergency Room complaining of anxiety and a note by . indicated that she discussed with Ms. Wilkerson "ways to handle anxiety." No mention in further notes indicated that anxiety issues were raised with her treating psychiatrist.

In early July 2001, Ms. Wilkerson went to the Emergency Room of the local hospital because of a conflict with the supervising house-staff. A note by Ms. indicated that legal action might occur due to misuse of ER services. No mention is made of any evaluation conducted. In fact, the hospital summary indicated that . of the Census Reduction Team came to pick the patient up, and no evaluation was done. Ms. Wilkerson's reason for entering the emergency department is that she was having difficulty breathing, was anxious, and she was not sure whether it was "anxiety or a heart attack." She was diagnosed with Paranoid Schizophrenia; no mention of anxiety is made in the diagnosis.

Her last medication management visit was on July 19, 2001. She was taking Haldol IM, 200 mg a month, Haldol, 5 mg twice a day, Cogentin 1 mg in the evening, and Ativan 0.5 mg four times a day. Her physician noted "Teresa returns for med visit. She continues to request med changes. She consistently wants to try atypicals but she has been stable on current regimen.

Teresa does c/o (complain of) AH (auditory hallucination) at times but no significant behavioral changes. Calls 911, believes heart attacks occurring. She is not making use of Ativan regularly. She had multiple c/o about living arrangement, and wanted to go to the hospital. accompanied her today and did note relate any behaviors that might be uncharacteristic for Teresa." Staff also noted that the patient wanted to have her medications changed and this was a frequent and repeated request. In a case note by , it is noted that Ms. Wilkerson was complaining of weakness and rapid heart beat at times. This was not evaluated.

In August of 2001 she was residing in the community and her treatment plans called for continued community tenure. A treatment goal was to keep her out of the hospital. Ms. Wilkerson's mother stated in a telephonic interview on February 26, 2002, that she and her husband were not in agreement with the plan to keep their daughter out of the hospital "at all costs." She stated: "I always felt that there was a dual problem with Teresa, she had problems with anxiety and would go to the hospital when she needed help. She came to depend on going to the hospital for help. On the weekend before her death, she begged the house staff to let her go to the hospital but the woman said: 'you're just putting-on in order to get attention.' If they let her go to the hospital, she wouldn't be dead. That program lied to us. They said she would have enough supervision and would be taken care of in the community. They weren't with her all the time at all. She only went to the hospital when she was frustrated and overwhelmed. They put her in jail once to try to teach her a lesson. You don't treat someone like that with mental illness that way; you find out what's wrong and give them some treatment."

The clinical records indicate that on the weekend before her death, Teresa Wilkerson and her caseworker spoke on the telephone two times and reported taking her medications. Her caseworker was informed that Ms. Wilkerson was angry on August 26th and was requesting that her medication be changed; she wanted to be hospitalized. She left the house abruptly and staff thought she was going to a restaurant to call 911, which was usual for her, but instead had jumped off a bridge killing herself. The details from a note by on August 26, 2001 indicate that the house on-call worker notified the ER staff by phone that they might be getting a

call from Ms. Wilkerson "due to her tendency to call 911." There was a plan to initiate involuntary commitment procedures when she was in the ER because of "her behaviors and level of agitation.

OPINION: Teresa Wilkerson was suffering from a Schizoaffective Disorder, and had, at the least, Borderline Intellectual Functioning. Many issues came into play and resulted in her unfortunate death. These issues are treatment-related, diagnosis-related, and systems management-related. I am least qualified to comment on the latter, but will attempt to shed some light in this area.

Ms. Wilkerson repeatedly presented to treatment settings with symptoms of anxiety and depression, suicidality, and sedation side-effects from her medication. She was clearly, at times, suffering for akisthesia, as noted in the medical record. The two times when her clinical condition was noted to be stable was when she was being treated with an antidepressant and when she was treated with Clozaril. These two medications seemed to target the anxiety, and depressive symptoms which were present and had few side-effects. The fact that her diagnosis changed so frequently and that there appeared to be only one instance when an effort was made (through psychological testing) to clarify the diagnosis, meant that Ms. Wilkerson had a treatment plan that neither assessed the nature of her dysfunction and limitations, nor assessed her strengths in light of these deficiencies.

Even on the day of her death, the note by staff assigned to her care wrote that Ms. Wilkerson had a long history of "Schizophrenia," while the treatment plan clearly stated that she was suffering from Schizoaffective Disorder, Bipolar Type. Dr. , in his notes indicated that the focus of the psychiatric treatment was Schizophrenia, Paranoid type. This was a major dis-connection in the treatment team regarding the presence of an affective component of her illness and I believe that this dis-connection led to misinterpretations of her behaviors, and overall limited that success of her care.

Ms. Wilkerson used clonazepam and lorazepam for her principle anxiety relief but was often sedated and began modifying her medication regimen on her own. She did not want, it appeared from the medical record, to be sedated or anxious and she was apparently trying to get relief in both areas. I believe this was interpreted as "power struggles" with the medication, and "non-compliance." She also had nicotine dependence, and while this was mentioned in the medical record as a contributor to anxiety, no effort to treat this condition was documented.

In her last medication visit in July of 2001, her physician noted that she "consistently wants to try atypicals." Because of side-effects of older medications and a more broad-spectrum symptom control which these newer medications possess, Ms. Wilkerson's request should have been honored. She was noted to have a good response to Clozaril in the past, but it was not clear whether he treating psychiatrists had access to this information. Dr. also wrote that Ms. Wilkerson was complaining of having heart attacks; perhaps this was Ms. Wilkerson's description of panic. The standard of care in July 2001 would have been to evaluate the cardiac status fully, treat the panic with an SSRI (a medication which was reported to be effective in her care in the past), and change the patient to an atypical antipsychotic for improved symptom management. Many of her behaviors, which appeared manipulative, could have been explained by panic and anxiety; consider the frequent ER visits and impulsive, agitated behaviors when frustrated. The standard of care, once panic attacks were diagnosed, would have been to evaluate the patient for the use of an SSRI. Even if her psychiatrist noted that there was a diagnosis of Schizoaffective Disorder, Bipolar Type, it would have been appropriate to consider a mood stabilizer or antidepressant, which would have also helped with impulsivity.

Her inability to conform to her medication regimen during her care and perhaps her difficulties in expressing her needs and desires appropriately may have been a function of her cognitive capacity, rather than a personality disorder. It is important to note that when her intellectual functioning was addressed in the diagnosis, less emphasis is placed on the features of a personality disorder. In some cognitively impaired individuals, the inability to appropriately interact can be seen as a flaw in personality. Regardless, this cognitive limitation, at least

recognized by some social workers, nurses, physicians, and her family, should have been addressed in treatment planning. Modifications in the treatment plan and approach to the patient's adaptation in the community based on the patient's level of understanding should have been made. Had these issues been understood, the focus of the treatment team might have been modified and keeping Ms. Wilkerson in the community more successful.

Her sad death was the product of the treatment team's inability to recognize the degree of distress this patient was in and their reliance on the theory that her behaviors was based on manipulation in the service of her dependency needs. Another theory of her behavior is that she was overwhelmed by her affective symptoms and did not have sufficient interpersonal skills to make her needs known in an appropriate fashion. Her mother indicated in our conversation that "Theresa had come to rely on the hospital" for help when she was overwhelmed. Had her anxiety been more directly treated, an atypical antipsychotic agent used (she asked for one at a time following her experience with Clozaril) which had fewer side-effects, Ms. Wilkerson might not have been so desperate on the day of her suicide. Had the entire treatment team understood the nature of her symptoms and her significant distress which appeared throughout the clinical record, and had a unified treatment plan based on agreed-upon diagnosis, her untimely death may have been prevented.

While it is beyond the scope of this review to investigate the organizational response to caring for patients like Ms. Teresa Wilkerson, it is important to note that her treating physician, Dr. strongly felt that her needs would have been served better in a higher intensity treatment setting. He acknowledged, I believe correctly, that one has to work with the services that are available. What was unfortunate in this case is that there was no documented (or otherwise noted) review of that community placement process after it occurred. The treatment team seemed to be struggling with a set of circumstances that would have ultimately led to disaster for this type of patient.

I am also convinced from that telephone interactions with all parties, that the primary goal

of the treaters was to help Ms. Wilkerson in her community placement. There was no evidence from my review of the records, or in speaking to individuals involved in her care that malicious intent was part of the treatment setting. All individuals spoke as being genuinely concerned about her care, and Dr. vas especially interested in being involved in some type of system reform. Dr. stated that he would fax and mail a letter documenting his interest in reform of the care of the chronically mentally ill in the community, but as of the submission of this report, no letter has been received. Should this communication be received, it will be attached in an addendum to this report.

If there are any questions regarding this report or the conclusions stated herein, please contact me at the above address.

Ronald J. Koshes, M.D.

March 8, 2002

EXHIBIT B

April 24, 2002
705 Hayes Drive
Lynchburg, VA 24502

Jonathan G. Martinis
Managing Attorney
Department of Rights for Virginians with Disabilities
Ninth Street Office Building
202 North 9th Street, 9th Floor
Richmond, VA 23219

RE: Statement for record regarding
DRVD's investigation into the death of
Theresa Wilkerson

Dear Martinis,

What happened to Theresa at the hands of her caregivers at Central Community Services was carelessness, which amounted to a reckless disregard for her safety and life. From this report the negligence while she was under the continuing care of CVCS over an extended period of time was so great it appears to be a conscious violation of her right to safety. The negligence is more than simple inadvertence, but it is just shy of being intentionally vile. If one has contracted to take care of another's life as CVCS did in the case of Theresa, then this negligence is the failure by CVCS staff collectively to actively pursue the same level of care for Theresa that they would take in relation to their own life and/or the life of their next of kin.

Two suicide attempts made by Theresa which were known to staff at Central VA Community Services but not mentioned in the Draft Report of the Department of Rights for Virginians with Disabilities are as follows:

- On July 12, 1991, Theresa took an overdose of prescription medication
- Theresa resided at Franklin Manor, an adult care residence from August 27, 1991 through November 12, 1991. While there Teresa left the home and ran in front of a truck.

Other noteworthy occurrences are as follows:

- While living at 502 Victoria (a home owned an operated by CVCS), Theresa called 911 on April 29, 2000. Police came but could not reach anyone with the CVCS Census Reduction Program to talk with.
- On May 11, 2000, Don & Dorothy Wilkerson met with CVCS Management regarding deficiencies at the home at 502 Victoria Avenue. Such deficiencies included inadequate staffing and general safety concerns.
- On February 1, 2001, Don & Dorothy Wilkerson met with the Census Reduction Staff again regarding deficiencies at the home at 502 Victoria Avenue. Such deficiencies included inadequate staffing and general safety concerns.

Investigating and issuing a report on what happened to Theresa is important but what is more important is what is going to happen as a result of it. Will the CSB assume legal responsibility for misdiagnosing her for years and for saying "she was looking for attention" when in fact had they diagnosed her correctly they would have known it came from her illness. The direct result was negligence on the CSB's part. I want to be sure that this will never happen to another family again.

Theresa's name should be used throughout the report and in the expert's findings.

Who will be held legally accountable for failing to take appropriate steps to protect Theresa's life? Will it be?

- Central VA Community Services and/or individual staff members; and/or
- The City of Lynchburg and/or the individual members of City Counsel for failing to install protective fencing on Rivermont Bridge from which Theresa jumped ending her life but not our hope.

In this regard we must act to prevent similar tragic deaths of persons with mental disabilities in the greater Lynchburg community. The public has a right to know the answers.

Sincerely,

W. Don Wilkerson

EXHIBIT C

Augustine J. Fagan, Executive Director
Administration Offices
2241 Langhorne Road
Lynchburg, VA 24501
(434) 847-8050
FAX (434) 847-8099

Central Virginia Community Services

Fax

To: Jonathan G. Martinis **From:** Augustine J. Fagan

Fax: 804-225-3221 **Pages:** 10

Phone: **Date:** 04/30/02

Re: Attached Response from CVCSB **CC:**

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

John Fagan

CENTRAL VIRGINIA
COMMUNITY SERVICES

2241 LANGHORNE ROAD• LYNCHBURG, VA 24501
434-847-8050 • TDD #434-847-8062 • FAX #434-847-6099

April 30, 2002

Mr. Jonathan G. Martinis, Managing Attorney
Department for Rights of Virginians with Disabilities
202 North 9th Street, 9th Floor
Richmond, VA 23219

Dear Mr. Martinis:

I am faxing to you the response of Central Virginia Community Services to DRVD Case #02-0182. Your letter of April 11, 2002 allowed us until May 1, 2002 to submit written comments on the report. Since the report was completed and reviewed by our attorney, I am sending it in earlier than my fax of today indicated.

By this letter, Central Virginia Community Services gives you permission to include these comments when you publish and make public your final report, including your publication on the internet. We ask that names of our staff, however, be redacted when publishing on the internet.

Please contact me if you have any questions.

Sincerely,

Augustine J. Fagan
Executive Director

RESPONSE TO DRVD INVESTIGATION REPORT
DRVD Case #02-0182

Introduction

Central Virginia Community Services rejects the finding that it was negligent in its treatment and care of Theresa Wilkerson. Although neglect is alleged by the Department for Rights of Virginians with Disabilities (DRVD) in their report, nothing in the report of the psychiatrist hired by DRVD, Dr. Koshes, indicates that her plan of care met the legal definition of neglect. We are advised by legal counsel that to satisfy that definition you would have to show actual negligence in providing treatment, i.e., treatment that falls below the standard of care. It is not enough just to assert a disagreement among professionals over what course of treatment should be followed. Having death by suicide as an unexpected outcome does not establish negligence.

In his report, Dr. Koshes does not allege malpractice based on his reading of the extensive record of Ms. Wilkerson. Three other psychiatrists—Drs. , , and —reviewed the same record and found no evidence of neglect or inappropriate treatment. They found that the diagnosis was appropriate and the treatment plan was based on that appropriate diagnosis. In a follow-up letter to Dr. Koshes from Dr. , who was interviewed by telephone by Dr. Koshes, Dr. stated: "I think Theresa Wilkerson in my clinical opinion received an appropriate level of care and monitoring per standard of care." Dr. letter was not quoted in Dr. Koshes' report.

There is no reference in the report to the fact that both the Department of Human Rights and the Office of Licensure conducted a thorough investigation of Ms. Wilkerson's death by suicide on September 5, 2001 and issued a report. No abuse, neglect or violations of any regulations were found by their investigation.

The statement in the report that "Ms. Wilkerson died a preventable death," is rash and without foundation. Ms. Wilkerson's death was completely unexpected and was more of an impulsive action by a woman with a long history of very serious mental illness rather than the result of misdiagnosis and an inadequate treatment plan that culminated in her death as the investigation report contends. As stated, Ms. Wilkerson was properly diagnosed and a treatment plan based on that diagnosis was created and followed by her direct care staff. To support our position, we present the following response.

Preliminary Concerns and Observations

Before commenting in detail on the Investigation Report regarding the death by suicide of Theresa Wilkerson, Central Virginia Community Services has the following concerns and observations regarding the Investigative Report:

The report summarizes a seven-month investigation making a number of detailed allegations and observations. Central Virginia Community Services was given only two weeks to respond to this report. An extension was requested to allow for a more comprehensive response. This request was denied by the Investigator and Executive Director of the Department for Rights of Virginians with Disabilities (DRVD).

2. A major concern was the failure of DRVD or their hired psychiatrist, Dr. Ronald Koshes, to consult with the Medical Director at Central Virginia Community Services at the time of the suicide, Dr. . Dr. was very well acquainted with Ms. Wilkerson and provided critical information for our response. Dr. Koshes called and asked that Dr. contact him. Dr. called him back and left a message for Dr. Koshes to return the call. Dr. Koshes completed his report without making contact with Dr. , thus leaving out of his report a critical source of information in the diagnosing and treating of Ms. Wilkerson. We can only conclude that Dr. Koshes had a deadline imposed by the DRVD that did not allow time for him to conduct a telephone interview with Dr. . Certainly, in a matter of this importance, sufficient time should have been given to Dr. Koshes to conduct a complete investigation involving, at a minimum, an interview with the Medical Director Psychiatrist at Central Virginia Community Services. In addition, the failure to interview Dr. leads us to believe that there was an assumption by the investigators that there was neglect in care and the investigation sought to prove neglect rather than take adequate time to gain important information by interviewing the Medical Director who knew Ms. Wilkerson well.
3. The diagnosis and prescribing of medications for people with serious mental illness is not an exact science and it is not unusual for psychiatrists to differ from other psychiatrists in arriving at a diagnosis, and to prescribe differing combinations of medications to treat symptoms. The psychiatrist for Central Virginia Community Services diagnosed and prescribed medications based on a face-to-face evaluation of Ms. Wilkerson and with the current observations of those who cared for her on a daily basis. The conclusions of the DRVD psychiatrist, Dr. Koshes, were reached by a review of the written record only. His conclusive findings of improper diagnosis and prescribing of medications by our direct care physicians do not take into account this serious disadvantage he was working under.

4. DRVD's response complimented staff for their caring but made it sound like they were kind but not very competent. Nothing could be further from the truth. In addition to being caring and very concerned about the welfare of Ms. Wilkerson, both staff members have over seven years of experience working with people with serious mental illness. Even Mr. Jonathan Martinis, Managing Attorney for DRVD, commented to the Executive Director of Central Virginia Community Services during the interview with him in Richmond that he was impressed with how well this agency was able to retain competent staff in these positions. He felt we were a model for other CSBs in this regard and stated that he would like to visit and talk with us about strategies for retaining direct care staff in these key positions for the long term. Mr. Martinis repeated these sentiments to our Department Director of Adult and Family Services when he interviewed her.
5. The report seems clear in the belief that Ms. Wilkerson should have been treated in a state mental health facility and not in the community. However, Ms. Wilkerson did not meet criteria for long term treatment in a hospital setting. This was confirmed each time she was assessed for hospitalization at the emergency room. When she was hospitalized in January 2001 at Catawba Hospital, the admitting staff at Catawba did not see a need for that hospitalization and she was discharged back to the community. Her voluntary treatment plan in the community was implemented by a very intensive treatment plan through the Census Reduction Project.
6. Our review of Ms. Wilkerson's record leads us to agree that in our documentation we omitted discussion of the various diagnoses that would shed light on reasons for our treatment plan responses. We also agree that we could improve the extent to which we describe the decisions about diagnosis and treatment planning in the chart. We further agree that in the progress notes we could provide more extensive documentation regarding what was meant by frequently used terms such as "baseline" and "stable" to describe the consumer's behavior.

Response to Key Elements in Report

In the Summary of Findings on page 1 of the report, the investigator states the basis for his conclusion that Ms. Wilkerson died a preventable death as follows:

> *In particular, the failure of Ms. Wilkerson's community service and health care workers to recognize and treat her Schizoaffective Disorder and CVCSB's determination that Ms. Wilkerson's behaviors were false and manipulative, rather than symptoms of her Schizoaffective Disorder, resulted in a failure to create and/or implement an appropriate treatment plan.*

Response to Part I: ". *the failure . . . to recognize and treat her Schizoaffective Disorder . . ."*

- Our staff did address and respond, on a daily basis, to the symptoms of Ms. Wilkerson's illness. She had an active treatment plan that recognized both the Schizoaffective Disorder diagnosed at Southern Virginia Mental Health Institute and the other working diagnosis of Schizophrenia, Paranoid type, given to her at Catawba Hospital. In the opinion of our psychiatrists, Ms. Wilkerson did not meet the consistent affective component of the Schizoaffective Disorder, Bipolar Type diagnosis on an outpatient basis. She clearly did not meet criteria for mania. Her depressive symptoms were short lived and resulted in impulsive rather than consistent periods of depression lasting for at least two weeks.

  It may be argued that an individual in a State Hospital may exhibit more symptoms of depression and restless mood, which may be interpreted by inpatient staff as schizoaffective. In the community the individual is not in a locked unit, has more choices, is less subservient to staff demands, and can act on impulsive thoughts. We did have differences of diagnostic impressions throughout Ms. Wilkerson's mental health record of over 42 years. It is not surprising that over such a period of time, when there is more than one treating physician, there may well be more than one opinion.

- Ms. Wilkerson was being treated with the highest standards of professional care available in our community. Her symptoms of mental illness were considered to be serious and true reflections of an illness that had been treated for 42 years in the various diagnoses in the schizophrenic spectrum. These included the discharge diagnosis from Southern Virginia Mental Health Institute of Schizoaffective Disorder and the discharge diagnosis from Catawba Hospital in January, 2001 of Schizophrenia.

  The primary reason that Ms. Wilkerson was accepted into the Census Reduction project and approved by the Department of Mental Health, Mental Retardation, and Substance Abuse Services for a community placement plan costing nearly $100,000 was that the Department of Mental Health, State Hospital staff, Census Reduction Project staff, and CVCS Mental Health staff all agreed that her illness, which had resulted in a high number of in-patient hospital bed days, required an intense level of care and supervision in the community setting. We agreed to direct this special funding and assign staff very experienced in comprehensive wrap-around services to meet the services needs of this individual who voluntarily entered this program. Otherwise, she would have continued her pattern of rotating in and out of State Hospitals and into Adult Home placements in our catchment area which do not have trained mental health professionals on staff.

Response to Part II: *" . . . CVCSB's determination that Ms. Wilkerson's behaviors were false and manipulative, rather than symptoms of her Schizoaffective Disorder, resulted in a failure to create and/or implement an appropriate treatment plan."*

- The record indicates that our psychiatrists and other direct care staff did respond to her somatic complaints, her symptoms of anxiety, and her requests for atypical medications. She was treated with atypical medications, Selective Serotonin Reuptake Inhibitors (SSRIs), and anti-anxiety medication. Our staff was very well aware of the seriousness of her mental illness and implemented a treatment plan that addressed the components of her mental illness.

- CVCSB's psychiatrists are in agreement that we did in fact pay very close attention to the signs and symptoms of Ms. Wilkerson's mental illness, and that the effectiveness of the medication, Clozaril, in treating Ms. Wilkerson confirmed the diagnosis of Schizophrenia. This medication resulted in her most positive response for the longest period of time. The sad fact is that she was unable to be compliant with the blood draws required while on Clozaril and this medication had to be discontinued. She was also tried on Risperdol and Zyprexa. An injectable form of Haldol had to be given due to non-compliance with other medications of choice for Schizophrenia. The medication regimen did not differ from episodes of care when the primary diagnosis was schizoaffective disorder.

- We did not feel that Ms. Wilkerson met the full criteria for Borderline Personality Disorder as she did not self-mutilate and did not make repeated suicide attempts. We do believe that she did possess traits of borderline personality disorder, which may have similar symptoms as Schizoaffective Disorder, and the treatment plan responded to those traits.

  It is very common for Mental Health consumers to carry various diagnoses over an extended period of treatment. All of the diagnoses listed were appropriate at the point in time her presenting symptoms were evaluated. Ms. Wilkerson's diagnosis changed within the broad spectrum of Schizoaffective Disorder and Schizophrenia from one hospitalization to another and reflected the seriousness of her illness. The treatment plan and response to her symptoms included an awareness of the entire history of treatment for Ms. Wilkerson.

  Our staff did not at any time independently determine that Ms. Wilkerson's symptoms were false. We treated her on a daily basis with a highly intensive level of staff intervention on an out-patient basis. We considered carefully her requests for changes in

medications and place of residence. Treatment staff responded appropriately to her requests and also helped her consider a variety of options in her voluntary treatment.

- Professionals other than our own treatment staff helped to determine appropriate treatment, including medications needed. While she was being treated in the community-based Census Reduction Project, she had only one admission to a state hospital and that was in January 2001. She was admitted to Catawba Hospital at that time. As previously noted, the admitting staff at Catawba did not see a need for that hospitalization and discharged her back to the community. Based on their evaluation, they discontinued her anti-depressant before discharge. At each of her many visits to the Emergency Room, Ms. Wilkerson was evaluated by Medical and Mental Health Staff employed by Centra Health. During these times, Ms. Wilkerson was given a thorough assessment for a higher level of care. However, based on her presenting symptoms, most of her ER visits resulted in returning to her community placement. She was admitted to inpatient care whenever she met the criteria for hospitalization.

- Ms. Wilkerson's treatment plan was designed to closely mirror her needs as determined by her diagnosis and by her presenting symptoms. The treatment and placement plan offered intense supervision in a least restrictive independent living situation that was very much in keeping with her diagnosis.

- As required of treatment plans developed for participants in the Census Reduction Project, our treatment plans were entered in the record, signed by the consumer, and approved by the Department of Mental Health. Mental health professionals at the state hospitals treating Ms. Wilkerson were also in agreement with the treatment plans through the discharge planning process.

Response to report's contention that Ms. Wilkerson had "cognitive impairment" (Dr. Koshes report, page 3, Investigator's report, page 3) **or mental retardation that was not considered in her treatment.**

- The Wilkerson parents were understandably very active in their pursuit of more funding to serve their daughters. As part of this effort, they had them evaluated for possible mental retardation which would make them eligible for Medicaid Waiver Funding. On January 13, 1995, Ms. Wilkerson was evaluated by the Division Director for Mental Retardation Services, , for eligibility. Ms. concluded that mental retardation was not an appropriate diagnosis based on evidence that included the following:

Evidence in the record of receiving a high school diploma where she ranked 329 of 615 in her high school class.
2. She attended Phillips Business College and focused on Key Punch Operations. She worked as a Key Punch Operator for one year.
3. She never participated in special education classes in school.
4. She graduated high school with a grade point average of 85.22.

- Based on the above information, it would not have been appropriate to include consideration of mental retardation or cognitive impairment in Ms. Wilkerson's treatment plan.

- The Wilkersons were then very vocal in their attempts to get additional funding for persons with mental illness in institutions that matched the funding available to adults with mental retardation. They were in agreement that both of their daughters were eligible for Mental Health Census Reduction funding when this funding became available.

Response to "Chronology of Events from April 2000 – August 2001

- The case notations included in the DRVD report were highly selective and left out significant information. Of particular concern was the omission of notes just prior to Ms. Wilkerson's death that reveal no indications of her being suicidal: August 10, reporting no symptoms; August 13, visit with parents with no report of symptoms; and August 24, visit with parents that went well, where they discussed her schizophrenia and went out to eat after the visit. The first note on August 26, the day Ms. Wilkerson completed suicide, noted no problems.

- In this section, the numerous calls that Ms. Wilkerson made to 911 were a pattern of behavior not limited to this time frame. She had history for over ten years, at every placement, of calling 911 personnel and then chatting with the staff without presentation of serious symptoms of depression or medical issues. It is clear that no staff of 911, police, or direct Mental Health staff interfered with her right to call emergency personnel herself. It was the firm conviction of direct care staff that on the day of her death she was again going across the bridge to call 911 as was her history and pattern of behavior. The staff member was so convinced that she called the Emergency Room to inform staff there that Theresa was headed toward the restaurant on the other side of the bridge to call 911 and she would likely need an emergency mental health evaluation.

Conclusion

We feel we have addressed the major elements of the Investigation Report sent to us by DRVD. However, we again express our concern that we were not given sufficient time to provide a more comprehensive response.

As noted in our Introduction, Central Virginia Community Services rejects the finding that it was negligent in any way in its treatment and care of Theresa Wilkerson. On the contrary, Ms. Wilkerson received a high quality and intense amount of services from very well prepared, professional staff during the period of her stay in our community. Her individual treatment plan was based on her current diagnosis and reflected both her diagnosis and presenting needs. As a result of her treatment and the caring approach of those staff members working with her, Ms. Wilkerson was able to enjoy a higher quality of life in her home community than could ever be realized in an institutional setting. Sadly for her, her family, and for her caregivers, this higher quality of life came to an end with her unexpected and tragic death by suicide on Sunday afternoon, August 26, 2001.

Submitted by:

Augustine J. Fagan, Executive Director
Central Virginia Community Services
2241 Langhorne Road
Lynchburg, Virginia 24501

May 1, 2002